Authorization for Release or Exchange of Information

I hereby authorize: _____
_____
_____
(Agency/Program – full name, address and phone #)

☐ To Release to: _____
☐ To Obtain from: (Name/Agency and Address)
(*check one or both)*

_____
(Name/Agency and Address)

_____
(Name/Agency and Address)

- If an Individual's Name is listed above, information may only be released to or obtained from that individual.

Information from
the records of: _____ _____
(Client Name) (DOB)

Other names used: _____

Purpose or need for disclosure:
_____
_____
_____

Types of Information to be disclosed:

___ School Reports (academic and behavioral)
___ Medical Reports/physical exams
___ Psychological assessment
___ Psychiatric evaluation (includes diagnosis/prognosis)
___ Alcohol or drug evaluation/treatment
___ Discharge or after-care plan
___ Treatment Plan
___ Social History
___ Treatment Summary
___ Discharge Summary
___ Legal Status/offenses
___ Other _____

I understand that my records are protected under state statutes governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in state statutes. This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereof.

Unless revoked by me in writing, this consent expires on _____.

_____ _____
Client signature Date signed

_____ _____
Parent/Guardian signature Date signed

_____ _____
Witness signature Date signed